MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:
EDS ADJUSTMENT UNIT
PO BOX _____(PAYER SPECIFIC)
RALEIGH, NC 27622

A CORRECTED CLAIM AND THE APPROPRIATE RA MUST BE ATTACHED

EDS USE ONLY

One Step:

EDS USE ONLY. DO NOT WRITE IN THIS BOX.

Provider #:_____ Provider Name:_____

Recipient Name:_____ MID#:_____

SUBMIT A COPY OF THE RA WITH REQUEST

Claim #: | | | | | | | | | | | | | | | | | | | |

Date Of Service: From:_____/_____/_____ To: _____/_____/_____

Billed Amount: $_____

Paid Amount: $_____

RA Date: _____/_____/_____

Please check (✓) reason for submitting the adjustment request:

☐ Over Payment ☐ Under Payment ☐ Full Recoupment ☐ Other

Please check (✓) changes or corrections to be made:

☐ Units ☐ Procedure/Diagnosis Code ☐ Billed Amount

☐ Dates of Service ☐ Patient Liability ☐ Further Medical Review

☐ Third Party Liability ☐ Medicare Adjustments ☐ Other

Please Specify Reason for Adjustment Request:

Signature Of Sender:

Date: / /

Phone #: ( ) -

EDS INTERNAL USE ONLY

Clerk ID#:_____ Sent to:_____ Date sent:_____/_____/_____

Reason for review:_____

Reviewed by:_____ Date reviewed:_____/_____/_____

Outcome of review:_____

Date received back in the Adjustment Department: _____/_____/_____

Revised: 08/21/00